Innovative Resource Group d/b/a
APS Healthcare

Request for Approval of Internet-Based Training

Provider: _____

Contact Person: _____

Email: _____

Fax: _____

As required by Chapter 512.3.5 we are requesting prior approval to use an internet provider for training.

Internet Provider Name: _____

Web Address: _____

Course Name (s): _____

_____

_____

Briefly describe why you feel this online training will best meet your training purposes.

Fax or mail completed form to:

APS Healthcare, Inc.
100 Capitol Street, Suite 600
Charleston, WV 25301
Attn: TBI Waiver Manager
Fax #: 866.607.9903

You will receive a written decision within 30 days of receipt of this request.